Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

RUPTURE OF THE LIVER; FORMATION OF CYSTIC SWELLING CONTAINING BILE-STAINED FLUID.

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THE case related in THE LANCET of March 21st, 1898 (p. 719), by Mr. C. Whipple under the above heading, and about which it is remarked that probably no similar one has been recorded, induces me to send the following notes of a case in which the symptoms were very similar, though there was no history of injury except muscular violence.

The case occurred a few years ago, and was under my care during the early stage only, so I am unable to give very complete notes. An officer, aged twenty-four years, who had been in India about a year, enjoying good health during that time, while training a raw and hard-mouthed pony with polo stick and ball suddenly felt pain in the right hypochondrium. After a few hours this became very severe, and on examining him it was found that there was severe pain and tenderness, most marked at a point just below the costal margin, a little to the right of the middle line. A slight puffy swelling could also be detected over the costal cartilages near this spot. The symptoms were attributed to rupture of some fibres of the rectus muscle and the patient was treated accordingly, but after a few days, the pain continuing, a swelling began to appear just below the costal margin. As fluctuation could be felt in this it was aspirated and one and a half pints of slightly blood-stained clear fluid were withdrawn. On examination, besides showing the presence of blood, the fluid gave the reactions for bile acids and pigment, but though carefully searched for no hydatid hooklets or membrane could be found. During this time the patient's temperature remained slightly above normal. From this time the case came under the care of another medical officer and the history was briefly as follows:—After about a week, the fluid having reaccumulated, the cyst was again aspirated and similar fluid removed. On a third tapping a short time later the fluid proved to be slightly purulent. The cavity was now opened by incision, about a pint of pus was removed, and a drainage-tube was inserted, but in spite of daily antiseptic irrigations of the cavity symptoms of septic infection appeared and the patient died from this. No post-mortem examination was made. The exact nature of this case has always remained a matter of uncertainty to me.

Malta.

GENU RECURVATUM.

BY ARTHUR S. TAYLOR, M.D. CANTAB., F.R.C.S. ENG.

THE condition known as genu recurvatum, described by Mr. Sheild in THE LANCET of May 28th, is sufficiently rare to make it desirable that all cases should be carefully noted, whether the deformity be severe or slight, in order that some rules should be arrived at for treatment. I think that the following case, though of a decidedly milder type, is very instructive.

The patient had had four children previously. The labour in each case had been tedious but straightforward. When she was in about the fourth month of her pregnancy she had a bad fall over a rope and injured her knee. This fact was, of course, made much of later, but the real interest of the accident lay in the question as to how far it may have been responsible for any malposition of the child's legs or for the course of after-events. It is curious how often there is a history of injury in these cases. The confinement was expected some time in February, 1898, and indeed about this time the liquor amnii escaped and feeble labour pains came on. The child, however, was not born until March 17th—i.e., one month later. The labour was difficult owing to the size of the child and forceps had to be used. The head was born in the first vertex position. The condition noticed at birth was the following. The legs appeared to be rather short but otherwise the whole body was well developed. The right leg was hyper-extended on the thigh about 10° beyond the straight and could only be flexed through 45°. There were two transverse furrows in front of the knee-joint. I thought I detected a rudimentary patella, but could not be positive. The left leg was hyper-extended about 30° and could not be flexed at all. The same transverse furrows were present, but there was no trace of a patella. I expected that the child would have to wear some kind of support for the rest of her life and ordered gentle massage and flexion. The condition on June 1st was as follows. Neither leg could be hyper-extended. Both legs could be flexed until the heel touched the buttock. There was a well-marked patella to be felt in the tendon of the right quadriceps extensor and a less well-marked one in the left tendon. The transverse furrows more or less remained.

This case appears to me to be rather one of faulty or arrested development than of malformation. The sequence of events seems to be this. The mother had a fall about one month later than the date at which the patella cartilage first appeared. Possibly the result of this was to extend the legs on the abdomen, the hip-joints being completely flexed. The quadriceps extensor being relaxed the stimulus necessary to the proper development of the sesamoid bone was removed. This condition would be accentuated in my case during the last month owing to the escape of the liquor amnii. The posterior crucial ligaments would also develop somewhat too short and limit flexion. The interesting point is that after birth and under normal conditions development has proceeded on the proper lines. In Mr. Sheild's case there was definite malformation and at the end of eight weeks no improvement had taken place. At the same time great injury is likely to follow forcible manipulations in such young subjects and no good will be done if the quadriceps extensor tendon is bound down to the shaft of the femur. If such a condition could be ascertained I would recommend subcutaneous section of any opposing bands. But in any case it seems worth while to wait a few months. Ossification commences in the patella in the third year and it will be easier to ascertain the exact condition when the child has developed somewhat, and the more simple cases like my own will escape operation.

Surbiton-hill.

TWO CASES OF THE EXTERNAL EAR COMPLETELY CUT OFF AND SUCCESSFULLY REPLACED.

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IN THE LANCET of June 4th Dr. William J. Brown reports an "Extraordinary Case of Horse-bite; the External Ear completely Bitten Off and Successfully Replaced." This paper recalls two cases which occurred some years ago in my own practice in which the external ear was completely cut off and which I successfully grafted on.

The first was that of a groom who came to fisticuffs with his horse in his loose box; he got knocked down and the horse trod on his head and completely cut off the man's external ear. The man secured his ear and came to me without delay.

The second case was that of a lad. While at play he rolled down the stone steps of an area. In his fall his external ear was cleanly cut off. His mother brought him at once to me, bringing the ear with her.

I adopted the same method in replacing the ears in both cases. As I had been successful in the first I hoped to be so in the second, as the result proved. The moment I got the ear I placed it in warm water nearly blood-heat, washed it and cleaned it; then I washed and prepared the patient. I applied the ear and noted all landmarks to make sure of its accurate adaptation. I passed interrupted horsehair sutures all round, without tying them until the last was passed; by this means the needle was able to be inserted through both edges, having noted the corresponding spots by jagged skin or otherwise. When the sutures were tied taut the ear fell into its exact position. I had no trouble with the curled-up edges. The ear was then covered with gauze and wool and bandaged. I ordered the application of a small flannel bag loosely filled with table salt; this to be heated in a saucepan over the